

Getting Lost in the Labyrinth of Medical Bills

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Published: June 22, 2012

<http://www.nytimes.com/2012/06/23/your-money/health-insura...>

This week's Your Money column discusses how difficult it has become for consumers to decipher how much they owe on their medical bills, and what those charges are based on.

Ask Jean Poole, a medical billing advocate, about her work helping people navigate the bewildering world of medical bills and [insurance](#) claims, and the stories pour out. There's the client who was billed almost \$11,000 for an 11-minute hand surgery. The [cancer](#) patient who was charged \$9,550.40 for a round of [chemotherapy](#) he never received.

Decoding Your Medical Bill

And then, there's the tale of the woman who came to Ms. Poole with a large rolling suitcase stuffed with bills for her 68-year-old husband, who had gone to the emergency room after he fell getting out of bed. The hospital's doctors discovered a series of problems — [kidney failure](#), blood and urinary tract infections, and a blood clot. Ultimately, he ended up staying in the hospital for two months and being transferred to a nursing home for rehabilitation.

Though the couple had two insurance policies — one through [Medicare](#) and a secondary policy at Blue Cross Blue Shield — they still received more than \$25,000 in medical bills and another \$65,000 from the nursing home. And some of them threatened collections if they weren't paid within days.

“Most people have a false sense of security if they have two insurances like this,” said [Ms. Poole](#), who is based in Virginia. “Many of the bills were confusing and she was very concerned there were errors and overcharges.”

Like most patients and their families, the ailing man's wife — who didn't want to be identified because of concern her husband's care could be compromised — simply wanted to figure out how much she really owed. That simple question has no simple answer, as an increasing number of consumers are finding out now that they are shouldering a greater share of their health care costs — whether they have a high-deductible plan, coinsurance or because they're underinsured (or not insured at all). How did the hospital or doctor arrive at these charges? Are the charges reasonable? And are the charges for services actually rendered?

Hospital care tends to be the most confounding, and experts say the charges you see on your bill are usually completely unrelated to the cost of providing the services (at hospitals, these list prices are called the “charge master file”). “The charges have no rhyme or reason at all,” [Gerard Anderson](#), director of the [Center for Hospital Finance and Management](#) at Johns Hopkins Bloomberg School of Public Health. “Why is 30 minutes in the operating room \$2,000 and not \$1,500? There is absolutely no basis for setting that charge. It is not based upon the cost, and it's not based upon the market forces, other than the whim of the C.F.O. of the hospital.”

And those charges don't really have any connection to what a hospital or medical provider will accept for payment, either. “If you line up five patients in their beds and they all have gall bladders removed and they get the same exact medication and services, if they have insurance or

if they don't have insurance, the hospital will get five different reimbursements, and none of it is based on cost," said [Holly Wallack](#), a medical billing advocate in Miami Beach. "The insurers negotiate a different rate, and if you are uninsured, underinsured or out of network, you are asked to pay full fare."

With the exception of Medicare and [Medicaid](#), experts say, the amount paid for services — or the price your insurers pay — is based on the market power of the insurance company on the one side and the hospitals and providers on the other, and the reimbursement agreements they ultimately reach. So large insurers that command a lot of market power may be able to negotiate lower rates than smaller companies with less influence. Or, insurers can place hospitals or providers on a preferred list, which may help bolster their business, in exchange for a lower reimbursement rate. On the other hand, well-regarded hospitals may command higher prices from insurers.

So let's say you have coverage through a high-deductible plan, where you're responsible for, say, the first \$5,000 or \$10,000. It's possible that you may have to pay more out of pocket for your medical services than your friend, also in a high-deductible plan, but one with an insurer that has greater negotiating power. "The ones that are affiliated with the larger insurers do best," Mr. Anderson said, adding that the uninsured have virtually no bargaining power, which is why they are expected to pay much more.

With so little pricing information available, expecting people to shop around for quality care at the lowest cost — something that's not always possible in emergency situations — is also asking a lot of consumers. "I have always found a bit cruel the much-mouthed suggestion that patients should have 'more skin in the game' and 'shop around for cost-effective health care' in the health care market," said [Uwe E. Reinhardt](#), a health policy expert and professor at Princeton University, "when patients have so little information easily available on prices and quality to those things."

President Obama's [Affordable Care Act](#), the [health care overhaul law](#) passed in 2010, tries to make [some improvements](#) (though the Supreme Court is expected to rule whether all or some of the law is constitutional this month). But while the law's changes help you [shop around for insurance policies](#) — specifically through its new [HealthCare.gov](#) Web site, a one-stop shop that lists all of your insurance options in one place — it's still unclear how effective the law will be for anyone comparing medical services.

Still, there are a handful of provisions that will help consumers on these issues. Starting in September, health insurers and group health plans must provide consumers a comprehensive [summary of their plan's benefits](#) and coverage in plain language. It also provides grants to help states start or improve services, known as [Consumer Assistance Programs](#), aimed at assisting people who have questions or problems about their health coverage. These programs, like Connecticut's [Office of the Healthcare Advocate](#), help people understand their plans, find coverage as well as assist with billing issues. Additionally, the new law gives patients the [right to appeal](#) their insurers' decisions after they are denied payment, for "plan or policy years" starting after July 1, 2011.

But one of the overarching ideas behind the law, according to Mike Hash, acting director of the Center for Consumer Information and Insurance Oversight, is to eventually encourage insurance plans to provide detailed information on, say, the quality of care and how much your share of the costs will be if you choose to have your knee surgery, for instance, at one provider versus

another. He also expects more clarity on out-of-pocket costs, which will be capped at reduced amounts for people who buy insurance through the state-run insurance exchanges and meet certain income requirements. But other out-of-pocket limits will apply to other people who buy plans inside and many plans outside the exchanges, experts said.

For now, there are some other helpful resources that exist, many of which can provide you with a rough idea of what some services might cost in a specific area, while some insurers offer tools to its customers as well. (I've listed some of them [in the blog post](#) attached to the online version of this column.)

As for the 68-year-old patient, Ms. Poole's detective work ultimately reduced his out-of-pocket costs by more than \$22,000, which left him responsible for about \$3,915. Since the couple didn't have long-term care insurance, he was also responsible for the nursing home's charges of \$65,000, which Ms. Poole said Medicare covered for only a short period of time. (Ms. Poole, a former emergency room nurse, who later received an M.B.A., generally charges about 25 percent of the savings found.)

She uncovered the savings in various places — there were charges for brand medications when the patient ordered generic, services that were double-billed, as well as charges for a private room that the patient did not request; he was only there because no other rooms were available. In another instance, a surgeon belatedly submitted his \$4,400 bill to the insurance company, so the claim was denied. That wasn't the patient's fault, but he was billed anyway. She lobbied the billing department to drop the charges, and they did.

Then, when the \$132,000 hospital bill came, the patient was told he owed \$9,200 and it had to be paid in 10 days. As it turns out, only one of the insurers had paid its share, which was hard to decipher from the bill. Ultimately, the patient only owed \$164.99. "There were three explanation of benefits from Blue Cross Blue Shield, each with an different amount due," she said, ranging from about \$164 to \$81,900. "How's that for confusion?"

All told, Ms. Poole spent about 96 hours dissecting each bill, line by line, comparing it with the providers' medical records and keeping track of it all in a complex spreadsheet.

"It's a broken system," she said.